



Facility Name & ID Number Columbus Park Nrsg. Rehab Ctr.# 0037960 Report Period Beginning: 01/01/04 Ending: 12/31/04

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>108</u>	Skilled (SNF)	<u>108</u>	<u>39,528</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>108</u>	Intermediate (ICF)	<u>108</u>	<u>39,528</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>216</u>	TOTALS	<u>216</u>	<u>79,056</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>15,125</u>	<u>276</u>	<u>3,944</u>	<u>19,345</u>	8
9	SNF/PED					9
10	ICF	<u>51,590</u>	<u>942</u>	<u>202</u>	<u>52,734</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>66,715</u>	<u>1,218</u>	<u>4,146</u>	<u>72,079</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 91.17%

D. How many bed-hold days during this year were paid by Public Aid?

1,628 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 1/1/92

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 1/1/92 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number  
of beds certified 54 and days of care provided 2,542Medicare Intermediary AdminaStar Federal

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/04 Fiscal Year: 12/31/04

\* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number

Columbus Park Nrsgr. Rehab Ctr.

# 0037960

Report Period Beginning:

01/01/04

Ending:

12/31/04

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	247,266	50,489	35,832	333,587		333,587	(20,613)	312,974			1
2	Food Purchase		315,417		315,417	(28,987)	286,430	(53)	286,377			2
3	Housekeeping	172,064	37,446		209,510		209,510	674	210,184			3
4	Laundry	89,667	36,332		125,999		125,999		125,999			4
5	Heat and Other Utilities			195,052	195,052		195,052	2,367	197,419			5
6	Maintenance	40,645	19,003	155,540	215,188		215,188	(35,366)	179,822			6
7	Other (specify):*							7,252	7,252			7
8	<b>TOTAL General Services</b>	549,642	458,687	386,424	1,394,753	(28,987)	1,365,766	(45,739)	1,320,027			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	2,108,190	126,649	393,799	2,628,638		2,628,638	(37,466)	2,591,172			10
10a	Therapy	111,183	2,027	23,123	136,333		136,333	(2,589)	133,744			10a
11	Activities	105,756	9,512	3,720	118,988		118,988		118,988			11
12	Social Services	99,829		8,429	108,258		108,258		108,258			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							4,363	4,363			15
16	<b>TOTAL Health Care and Programs</b>	2,424,958	138,188	436,271	2,999,417		2,999,417	(35,692)	2,963,725			16
	<b>C. General Administration</b>											
17	Administrative	120,183		548,631	668,814		668,814	(399,262)	269,552			17
18	Directors Fees											18
19	Professional Services			149,966	149,966	(138)	149,828	(110,034)	39,794			19
20	Dues, Fees, Subscriptions & Promotions			46,077	46,077		46,077	(14,786)	31,291			20
21	Clerical & General Office Expenses	98,682	25,979	197,319	321,980		321,980	(105,167)	216,813			21
22	Employee Benefits & Payroll Taxes			512,660	512,660	28,987	541,647	(314)	541,333			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,425	2,425		2,425	492	2,917			24
25	Other Admin. Staff Transportation			738	738		738	2,843	3,581			25
26	Insurance-Prop.Liab.Malpractice			162,082	162,082		162,082	14,746	176,828			26
27	Other (specify):*							22,293	22,293			27
28	<b>TOTAL General Administration</b>	218,865	25,979	1,619,898	1,864,742	28,849	1,893,591	(589,189)	1,304,402			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,193,465	622,854	2,442,593	6,258,912	(138)	6,258,774	(670,620)	5,588,154			29

\* Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

Page 4

Facility Name & ID Number      Columbus Park Nrsg. Rehab Ctr.      #0037960      Report Period Beginning:      01/01/04      Ending:      12/31/04

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			81,869	81,869		81,869	222,704	304,573			30
31	Amortization of Pre-Op. & Org.							4,610	4,610			31
32	Interest			42,215	42,215		42,215	626,204	668,419			32
33	Real Estate Taxes					138	138	184,530	184,668			33
34	Rent-Facility & Grounds			1,072,165	1,072,165		1,072,165	(1,072,165)				34
35	Rent-Equipment & Vehicles			11,463	11,463		11,463	3,934	15,397			35
36	Other (specify):*							101,247	101,247			36
37	<b>TOTAL Ownership</b>			1,207,712	1,207,712	138	1,207,850	71,064	1,278,914			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		119,512	239,076	358,588		358,588	(1,635)	356,953			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			118,584	118,584		118,584		118,584			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		119,512	357,660	477,172		477,172	(1,635)	475,537			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,193,465	742,366	4,007,965	7,943,796		7,943,796	(601,191)	7,342,605			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Columbus Park Nrsgr. Rehab Ctr.

# 0037960

Report Period Beginning: 01/01/04

Ending: 12/31/04

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(219,194)	30		9
10	Interest and Other Investment Income	(1)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(53)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,000)	20		18
19	Entertainment				19
20	Contributions	(1,600)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(156,338)	21		24
25	Fund Raising, Advertising and Promotional	(1,866)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(14)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(7,439)	20		28
29	Other-Attach Schedule	(37,836)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (425,341)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(175,850)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (175,850)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (601,191)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS			Page 5A
Columbus Park Nsg. Rehab Ctr.			
ID# 0037968			
Report Period Beginning:	01/01/84		
Ending:	12/31/84		
NON-ALLOWABLE EXPENSES			Sch. V Line
	Amount	Reference	
1 Tower Rent	\$ (16,280)	32	1
2 Jury Duty Income	(17)	19	2
3 Veterans Expense	(130)	19	3
4 Theft & Damage Loss	(131)	21	4
5 COPE Taxes	(5,313)	20	5
6 Building Company - Fees	(644)	20	6
7 Legal Fees - Collections	(523)	19	7
8 Legal Fees - Out of Period	(3,249)	19	8
9 PPA - Obsolescence Expense	(1,635)	20	9
10 Capitalized R&M	(18,004)	06	10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49			49
50			50
51			51
52			52
53			53
54			54
55			55
56			56
57			57
58			58
59			59
60			60
61			61
62			62
63			63
64			64
65			65
66			66
67			67
68			68
69			69
70			70
71			71
72			72
73			73
74			74
75			75
76			76
77			77
78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90			90
91			91
92			92
93			93
94			94
95			95
96			96
97			97
98			98
99			99
100			100
101 Total	(27,836)		101

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Columbus Park Nrsng. Rehab Ctr.

# 0037960

Report Period Beginning:

01/01/04

Ending:

12/31/04

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary					(15,218)	(5,395)						(20,613)	1
2	Food Purchase	(53)											(53)	2
3	Housekeeping			674									674	3
4	Laundry													4
5	Heat and Other Utilities			883	1,484								2,367	5
6	Maintenance	(18,004)		643	(12,687)		(5,132)		(186)				(35,366)	6
7	Other (specify):*				1,007	1,428	4,817						7,252	7
8	<b>TOTAL General Services</b>	<b>(18,057)</b>		<b>2,200</b>	<b>(10,196)</b>	<b>(13,790)</b>	<b>(5,710)</b>		<b>(186)</b>				<b>(45,739)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(147)			(23,869)				(13,450)				(37,466)	10
10a	Therapy						(2,589)						(2,589)	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				3,580		783						4,363	15
16	<b>TOTAL Health Care and Programs</b>	<b>(147)</b>			<b>(20,289)</b>		<b>(1,806)</b>		<b>(13,450)</b>				<b>(35,692)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			17,320	(65,702)	(346,560)	(4,320)						(399,262)	17
18	Directors Fees													18
19	Professional Services	(3,763)		(103,661)	344	14,542	(17,496)						(110,034)	19
20	Fees, Subscriptions & Promotions	(15,861)	644	212	219								(14,786)	20
21	Clerical & General Office Expenses	(156,483)		59,753	(8,437)								(105,167)	21
22	Employee Benefits & Payroll Taxes							(314)					(314)	22
23	Inservice Training & Education													23
24	Travel and Seminar			169	323								492	24
25	Other Admin. Staff Transportation			582	2,261								2,843	25
26	Insurance-Prop.Liab.Malpractice		13,609	422	715								14,746	26
27	Other (specify):*			10,238	4,218	7,837							22,293	27
28	<b>TOTAL General Administration</b>	<b>(176,107)</b>	<b>14,253</b>	<b>(14,965)</b>	<b>(66,059)</b>	<b>(324,181)</b>	<b>(21,816)</b>	<b>(314)</b>					<b>(589,189)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(194,311)</b>	<b>14,253</b>	<b>(12,765)</b>	<b>(96,544)</b>	<b>(337,971)</b>	<b>(29,332)</b>	<b>(314)</b>	<b>(13,636)</b>				<b>(670,620)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name &amp; ID Number Columbus Park Nrsrg. Rehab Ctr.

# 0037960

Report Period Beginning:

01/01/04

Ending:

12/31/04

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	(219,194)	436,958	2,087	2,853								222,704	30
31	Amortization of Pre-Op. & Org.		4,610										4,610	31
32	Interest	(10,201)	635,073	378	954								626,204	32
33	Real Estate Taxes		177,986	2,274	4,270								184,530	33
34	Rent-Facility & Grounds		(1,072,165)										(1,072,165)	34
35	Rent-Equipment & Vehicles			2,193	1,741								3,934	35
36	Other (specify):*		101,247										101,247	36
37	<b>TOTAL Ownership</b>	(229,395)	283,709	6,932	9,818								71,064	37
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(1,635)											(1,635)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>	(1,635)											(1,635)	44
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(425,341)	297,962	(5,833)	(86,726)	(337,971)	(29,332)	(314)	(13,636)				(601,191)	45



Facility Name & ID Number Columbus Park Nrsg. Rehab Ctr.# 0037960

Report Period Beginning:

01/01/04

Ending:

12/31/04

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Columbus Park LLC		Building Company

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 1,072,165	Columbus Park LLC	100.00%	\$	(1,072,165)	1
2	V	20 Fees		Columbus Park LLC	100.00%	644	644	2
3	V	36 Insurance - MIP		Columbus Park LLC	100.00%	101,247	101,247	3
4	V	26 Insurance - Property		Columbus Park LLC	100.00%	13,609	13,609	4
5	V	32 Interest - HUD		Columbus Park LLC	100.00%	635,718	635,718	5
6	V	33 Real Estate Tax		Columbus Park LLC	100.00%	177,986	177,986	6
7	V	32 Interest Income	645	Columbus Park LLC	100.00%		(645)	7
8	V	31 Amortization - HUD Fees		Columbus Park LLC	100.00%	4,610	4,610	8
9	V	30 Depreciation		Columbus Park LLC	100.00%	436,958	436,958	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,072,810			\$ 1,370,772	\$ * 297,962	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Columbus Park Nrsg. Rehab Ctr.

# 0037960

Report Period Beginning: 01/01/04

Ending: 12/31/04

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	3 HOUSEKEEPING	\$	PREFERRED BOOKKEEPING	100.00%	\$ 674	\$ 674 15
16	V	5 UTILITIES		PREFERRED BOOKKEEPING	100.00%	883	883 16
17	V	6 REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	643	643 17
18	V	17 ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	17,320	17,320 18
19	V	19 PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	1,399	1,399 19
20	V	20 DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	212	212 20
21	V	21 CLERICAL		PREFERRED BOOKKEEPING	100.00%	59,753	59,753 21
22	V	24 SEMINARS		PREFERRED BOOKKEEPING	100.00%	169	169 22
23	V	25 ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	582	582 23
24	V	26 INSURANCE		PREFERRED BOOKKEEPING	100.00%	422	422 24
25	V	27 EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	10,238	10,238 25
26	V	30 DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	2,087	2,087 26
27	V	32 INTEREST		PREFERRED BOOKKEEPING	100.00%	378	378 27
28	V	33 REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	2,274	2,274 28
29	V	35 EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	2,193	2,193 29
30	V						30
31	V						31
32	V	19 ACCOUNT/BOOKKEEPING	105,060	PREFERRED BOOKKEEPING	100.00%		(105,060) 32
33	V	19 COMPUTER	5,184	PREFERRED BOOKKEEPING	100.00%	5,184	33
34	V						34
35	V						35
36	V						36
37	V						37
38	V						38
39	Total		\$ 110,244			\$ 104,411	\$ * (5,833) 39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Columbus Park Nrsg. Rehab Ctr.

# 0037960

Report Period Beginning: 01/01/04

Ending: 12/31/04

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5 UTILITIES	\$	S.I.R. MANAGEMENT, INC.	100.00%	\$ 1,484	\$ 1,484	15
16	V	6 REPAIRS AND MAINT.	19,440	S.I.R. MANAGEMENT, INC.	100.00%	6,753	(12,687)	16
17	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	1,007	1,007	17
18	V	10 NURSING	42,768	S.I.R. MANAGEMENT, INC.	100.00%	18,899	(23,869)	18
19	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	3,580	3,580	19
20	V	17 ADMINISTRATIVE	75,816	S.I.R. MANAGEMENT, INC.	100.00%	10,114	(65,702)	20
21	V	19 PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	344	344	21
22	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	219	219	22
23	V	21 CLERICAL & GENERAL	22,032	S.I.R. MANAGEMENT, INC.	100.00%	13,595	(8,437)	23
24	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	323	323	24
25	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	2,261	2,261	25
26	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	715	715	26
27	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	4,218	4,218	27
28	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	2,853	2,853	28
29	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	954	954	29
30	V	33 REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	4,270	4,270	30
31	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	1,741	1,741	31
32	V							32
33	V	39 LEASED EQUIPMENT		S.I.R. MANAGEMENT, INC.	100.00%			33
34	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%			34
35	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%			35
36	V							36
37	V							37
38	V							38
39	Total		\$ 160,056			\$ 73,330	\$ * (86,726)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbus Park Nrsg. Rehab Ctr.# 0037960Report Period Beginning: 01/01/04Ending: 12/31/04

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 DIETARY SALARIES	\$ 22,032	S.I.R. MANAGEMENT, INC.	100.00%	\$ 6,814	\$ (15,218)	15
16	V	7 EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,428	1,428	16
17	V	17 ADMIN./LEGAL SALARIES	396,495	S.I.R. MANAGEMENT, INC.	100.00%	49,935	(346,560)	17
18	V	19 FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	14,542	14,542	18
19	V	27 EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	7,837	7,837	19
20	V							20
21	V	17 ADMIN. SALARY-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%			21
22	V	6 REPAIRS & MAINT.-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%			22
23	V	21 CLERICAL & GEN.-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%			23
24	V	26 AUTO INSURANCE-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%			24
25	V	27 EMP. BENEFITS-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%			25
26	V	35 AUTO LEASE-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%			26
27	V							27
28	V	17 ADMIN. SALARY-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%			28
29	V	21 CLERICAL & GEN.-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%			29
30	V	26 AUTO INSURANCE-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%			30
31	V	27 EMP. BENEFITS-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%			31
32	V	35 AUTO LEASE-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%			32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 418,527			\$ 80,556	\$ * (337,971)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbus Park Nrsg. Rehab Ctr.# 0037960Report Period Beginning: 01/01/04Ending: 12/31/04

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A SPECIAL REHAB	6,324	S.I.R. MANAGEMENT, INC.	100.00%	3,735	\$ (2,589)	15
16	V	15 EMP. BEN.-H. CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%	783	783	16
17	V							17
18	V	6 REPAIRS AND MAINT.	20,553	S.I.R. MANAGEMENT, INC.	100.00%	15,421	(5,132)	18
19	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	3,055	3,055	19
20	V							20
21	V							21
22	V	1 DIETICIAN SALARIES	13,800	S.I.R. MANAGEMENT, INC.	100.00%	8,405	(5,395)	22
23	V	7 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	1,762	1,762	23
24	V							24
25	V	19 LEGAL FEES	17,496	S.I.R. MANAGEMENT, INC.	100.00%		(17,496)	25
26	V							26
27	V	17 FEES	4,320	S.I.R. MANAGEMENT, INC.	100.00%		(4,320)	27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 62,493			\$ 33,161	\$ * (29,332)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbus Park Nrsg. Rehab Ctr.# 0037960Report Period Beginning: 01/01/04Ending: 12/31/04

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 EMPLOYEE HEALTH INSURANCE	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 57,771	\$ 57,771	15
16	V							16
17	V							17
18	V							18
19	V	22 EMPLOYEE HEALTH INSURANCE	58,085	CCS EMPLOYEE BENEFIT GROUP	100.00%		(58,085)	19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 58,085			\$ 57,771	\$ * (314)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Columbus Park Nrsg. Rehab Ctr.

# 0037960

Report Period Beginning: 01/01/04

Ending: 12/31/04

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	01 DIETARY	\$	XCEL MEDICAL SUPPLY, LLC	100.00%	\$	\$	15
16	V	02 FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%			16
17	V	03 HOUSEKEEPING		XCEL MEDICAL SUPPLY, LLC	100.00%			17
18	V	04 LAUNDRY		XCEL MEDICAL SUPPLY, LLC	100.00%			18
19	V	06 REPAIRS & MAINTENANCE	1,252	XCEL MEDICAL SUPPLY, LLC	100.00%	1,066	(186)	19
20	V	10 NURSING	90,658	XCEL MEDICAL SUPPLY, LLC	100.00%	77,208	(13,450)	20
21	V	10A THERAPY		XCEL MEDICAL SUPPLY, LLC	100.00%			21
22	V	12 SOCIAL SERVICE		XCEL MEDICAL SUPPLY, LLC	100.00%			22
23	V	21 CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%			23
24	V	22 EMPLOYEE BENEFITS		XCEL MEDICAL SUPPLY, LLC	100.00%			24
25	V	39 ANCILLARY		XCEL MEDICAL SUPPLY, LLC	100.00%			25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 91,910			\$ 78,274	\$ * (13,636)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbus Park Nrsg. Rehab Ctr.# 0037960Report Period Beginning: 01/01/04Ending: 12/31/04

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Columbus Park Nrsg. Rehab Ctr.# 0037960Report Period Beginning: 01/01/04Ending: 12/31/04

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbus Park Nrsg. Rehab Ctr.# 0037960Report Period Beginning: 01/01/04Ending: 12/31/04

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 7

Facility Name & ID Number Columbus Park Nrsgr. Rehab Ctr. # 0037960 Report Period Beginning: 01/01/04 Ending: 12/31/04

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Louise Bergthold	Shareholder	Administrative	4.25%	see attached	5.84	10.62%	SIR Salary	\$ 18,675	17-07	1
2	Tom Winter	Shareholder	Administrative	0.94%	see attached	6.42	10.70%	Pref Bkp Sal	17,320	17-07	2
3	Nenita Guzman	Shareholder	Dietary	1.89%	see attached	5.31	10.62%	SIR Salary	6,814	01-07	3
4	Eric Rothner	Shareholder	Administrative	3.77%	see attached	0.82	1.78%	SIR Salary	9,987	17-07	4
5	Adam Vales	Shareholder	Clerical	2.83%	see attached	0.38	0.95%	Alloc Salary	390	22-07	5
6	Leo Feigenbaum	Shareholder	Administrative	6.60%	see attached	1.00	1.59%	Mgmt Fee	36,000	17-03	6
7	Noah Wolff	Shareholder	Administrative	4.25%	see attached			Mgmt Fee	36,000	17-03	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 125,186		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbus Park Nrsng. Rehab Ctr. # 0037960 Report Period Beginning: 01/01/04 Ending: 12/31/04

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbus Park Nrsgr. Rehab Ctr.# 0037960

Report Period Beginning:

01/01/04Ending: 12/31/04

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization PREFERRED BOOKKEEPING SERVICES  
 Street Address 4100 WEST PRATT AVE.  
 City / State / Zip Code LINCOLNWOOD, IL. 60712  
 Phone Number ( 847) 674-5200  
 Fax Number ( 847) 674-5267

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOK./ACCNT.INCOME	927,958	10	\$ 5,955	\$ 105,060	\$ 674	1
2	5	UTILITIES	BOOK./ACCNT.INCOME	927,958	10	7,801	105,060	883	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME	927,958	10	5,680	105,060	643	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME	927,958	10	152,983	105,060	17,320	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME	927,958	10	12,360	105,060	1,399	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME	927,958	10	1,874	105,060	212	6
7	21	CLERICAL	BOOK./ACCNT.INCOME	927,958	10	527,777	105,060	59,753	7
8	24	SEMINARS	BOOK./ACCNT.INCOME	927,958	10	1,493	105,060	169	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME	927,958	10	5,142	105,060	582	9
10	26	INSURANCE	BOOK./ACCNT.INCOME	927,958	10	3,729	105,060	422	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME	927,958	10	90,428	105,060	10,238	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME	927,958	10	18,431	105,060	2,087	12
13	32	INTEREST	BOOK./ACCNT.INCOME	927,958	10	3,338	105,060	378	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME	927,958	10	20,087	105,060	2,274	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME	927,958	10	19,368	105,060	2,193	15
16									16
17									17
18									18
19	19	COMPUTER	DIRECT ALLOCATION					5,184	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 876,446	\$ 619,216	\$	104,411	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbus Park Nrsrg. Rehab Ctr. # 0037960 Report Period Beginning: 01/01/04 Ending: 12/31/04

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization S.I.R. MANAGEMENT, INC.  
 Street Address 6840 N. LINCOLN  
 City / State / Zip Code LINCOLNWOOD, IL. 60712  
 Phone Number ( 847) 675 -7979  
 Fax Number ( 847) 675 -0555

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5 UTILITIES	PATIENT DAYS	678,909	11	\$ 13,981	\$	72,079	\$ 1,484	1
2	6 REPAIRS AND MAINT.	PATIENT DAYS	678,909	11	63,606		72,079	6,753	2
3	7 EMP. BEN.-GEN. SERV.	PATIENT DAYS	678,909	11	9,483		72,079	1,007	3
4	10 NURSING	PATIENT DAYS	678,909	11	178,013	178,013	72,079	18,899	4
5	15 EMP. BEN.-H.C.	PATIENT DAYS	678,909	11	33,716		72,079	3,580	5
6	17 ADMINISTRATIVE	PATIENT DAYS	678,909	11	95,266	95,266	72,079	10,114	6
7	19 PROFESSIONAL FEES	PATIENT DAYS	678,909	11	3,242		72,079	344	7
8	20 FEES,SUBSCRIPTIONS	PATIENT DAYS	678,909	11	2,062		72,079	219	8
9	21 CLERICAL & GENERAL	PATIENT DAYS	678,909	11	128,049	90,910	72,079	13,595	9
10	24 EDUCATION & SEMINAR	PATIENT DAYS	678,909	11	3,040		72,079	323	10
11	25 OTHER ADMIN. STAFF TRANS	PATIENT DAYS	678,909	11	21,297		72,079	2,261	11
12	26 INSURANCE	PATIENT DAYS	678,909	11	6,736		72,079	715	12
13	27 EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	678,909	11	39,734		72,079	4,218	13
14	30 DEPRECIATION	PATIENT DAYS	678,909	11	26,873		72,079	2,853	14
15	32 INTEREST	PATIENT DAYS	678,909	11	8,988		72,079	954	15
16	33 REAL ESTATE TAXES	PATIENT DAYS	678,909	11	40,220		72,079	4,270	16
17	35 EQUIPMENT RENTAL	PATIENT DAYS	678,909	11	16,401		72,079	1,741	17
18									18
19	39 LEASED EQUIPMENT	LEASING INCOME	52,560	1					19
20	30 DEPRECIATION	LEASING INCOME	52,560	1	24,293				20
21	32 INTEREST	LEASING INCOME	52,560	1	6,298				21
22									22
23									23
24									24
25	TOTALS				\$ 721,298	\$ 410,443		\$ 73,330	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbus Park Nrsng. Rehab Ctr.# 0037960

Report Period Beginning:

01/01/04Ending: 12/31/04

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization S.I.R. MANAGEMENT, INC.Street Address 6840 N. LINCOLNCity / State / Zip Code LINCOLNWOOD, IL. 60712Phone Number ( 847) 675 -7979Fax Number ( 847) 675 -0555

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	DIETARY SALARIES	PATIENT DAYS	678,909	11	\$ 64,183	\$ 64,183	72,079	\$ 6,814	1
2	EMP. BEN.-DIETARY	PATIENT DAYS	678,909	11	13,453		72,079	1,428	2
3	ADMIN./LEGAL SALARIES	PATIENT DAYS	678,909	11	470,339	470,339	72,079	49,935	3
4	FINANCIAL CONSULTANT	PATIENT DAYS	678,909	11	136,972		72,079	14,542	4
5	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	678,909	11	73,815		72,079	7,837	5
6									6
7	17 ADMIN. SALARY-B. BARRISH	AVG HRS WKD	30	4	155,406	155,406			7
8	6 REPAIRS & MAINT.-B. BARRISH	AVG HRS WKD	30	4	1,462				8
9	21 CLERICAL & GEN.-B. BARRISH	AVG HRS WKD	30	4	1,426				9
10	26 AUTO INSURANCE-B. BARRISH	AVG HRS WKD	30	4	733				10
11	27 EMP. BENEFITS-B. BARRISH	AVG HRS WKD	30	4	32,115				11
12	35 AUTO LEASE-B. BARRISH	AVG HRS WKD	30	4	16,634				12
13									13
14	17 ADMIN. SALARY-M. GIANNINI	AVG HRS WKD	30	4	150,673	150,673			14
15	21 CLERICAL & GEN.-M. GIANNINI	AVG HRS WKD	30	4	560				15
16	26 AUTO INSURANCE-M. GIANNINI	AVG HRS WKD	30	4	726				16
17	27 EMP. BENEFITS-M. GIANNINI	AVG HRS WKD	30	4	31,946				17
18	35 AUTO LEASE-M. GIANNINI	AVG HRS WKD	30	4	6,756				18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,157,199	\$ 840,601		\$ 80,556	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbus Park Nrsng. Rehab Ctr. # 0037960 Report Period Beginning: 01/01/04 Ending: 12/31/04

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization S.I.R. MANAGEMENT, INC.  
 Street Address 6840 N. LINCOLN  
 City / State / Zip Code LINCOLNWOOD, IL. 60712  
 Phone Number ( 847) 675 -7979  
 Fax Number ( 847) 675 -0555

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10A SPECIAL REHAB	SPECIAL REHAB INC.	107,736	7	\$ 63,630	\$ 63,630	6,324	\$ 3,735	1
2	15 EMP. BEN.-H. CARE & PROG.	SPECIAL REHAB INC.	107,736	7	13,337		6,324	783	2
3									3
4	6 REPAIRS AND MAINT.	MAINTENANCE INC.	143,028	11	107,866	107,866	20,448	15,421	4
5	7 EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	143,028	11	21,371		20,448	3,055	5
6									6
7									7
8	1 DIETICIAN SALARIES	DIETICIAN SERVICE INC.	125,400	10	76,377	76,377	13,800	8,405	8
9	7 EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	125,400	10	16,008		13,800	1,762	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 298,589	\$ 247,873		\$ 33,161	25

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Columbus Park Nrsng. Rehab Ctr. # 0037960 Report Period Beginning: 01/01/04 Ending: 12/31/04

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization CCS EMPLOYEE BENEFITS GROUP, INC.  
 Street Address 4101 W. MAIN ST.  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number ( 847)905-4000  
 Fax Number ( 847)905-4040

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURANCE	DIRECT ALLOCATION		\$	\$		\$ 57,771	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 57,771	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbus Park Nrsgr. Rehab Ctr. # 0037960 Report Period Beginning: 01/01/04 Ending: 12/31/04

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization XCEL MEDICAL SUPPLY, LLC  
 Street Address 2201 MAIN STREET  
 City / State / Zip Code EVANSTON, IL 60202  
 Phone Number ( 847)328-7600  
 Fax Number ( 847)328-7615

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01 DIETARY	Direct Allocation			\$	\$		\$	1
2	02 FOOD	Direct Allocation							2
3	03 HOUSEKEEPING	Direct Allocation							3
4	04 LAUNDRY	Direct Allocation							4
5	06 REPAIRS & MAINTENANCE	Direct Allocation						1,066	5
6	10 NURSING	Direct Allocation						77,208	6
7	10A THERAPY	Direct Allocation							7
8	12 SOCIAL SERVICE	Direct Allocation							8
9	21 CLERICAL & GENERAL OFFICE	Direct Allocation							9
10	22 EMPLOYEE BENEFITS	Direct Allocation							10
11	39 ANCILLARY	Direct Allocation							11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 78,274	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbus Park Nrsng. Rehab Ctr. # 0037960 Report Period Beginning: 01/01/04 Ending: 12/31/04

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbus Park Nrsng. Rehab Ctr. # 0037960 Report Period Beginning: 01/01/04 Ending: 12/31/04

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbus Park Nrsng. Rehab Ctr. # 0037960 Report Period Beginning: 01/01/04 Ending: 12/31/04

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	HUD		X	Mortgage	\$88,228.00	9/9/03	\$ 11,316,100	\$ 11,142,912	9/9/33	5.6700	\$ 635,718	1	
2												2	
3												3	
4												4	
5	See Supplemental Schedule											5	
	Working Capital												
6	CIB Bank		X	Line of Credit				1,280,000			42,215	6	
7	Alloc. Preferred Bookkeeping		X								378	7	
8	See Supplemental Schedule										954	8	
9	TOTAL Facility Related				\$88,228.00		\$ 11,316,100	\$ 12,422,912			\$ 679,265	9	
	B. Non-Facility Related*												
10	Interest Income		X								(1)	10	
11	Interest Income - Bldg Co.		X								(645)	11	
12	Tower Rental Income		X								(10,200)	12	
13	See Supplemental Schedule											13	
14	TOTAL Non-Facility Related						\$	\$			\$ (10,846)	14	
15	TOTALS (line 9+line14)						\$ 11,316,100	\$ 12,422,912			\$ 668,419	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 101,247 Line # 36

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
6												6	
7	TOTAL Long-Term											7	
	Working Capital												
8	Allocation SIR Management		X				\$	\$			\$	954	8
9													9
10													10
11													11
12													12
13													13
14	TOTAL Working Capital											954	14
	B. Non-Facility Related*												
15							\$	\$			\$		15
16													16
17													17
18													18
19													19
20	TOTAL Non-Facility Related												20

- \* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT
- \*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name & ID Number **Columbus Park Nrsg. Rehab Ctr.**# **0037960** Report Period Beginning: **01/01/04** Ending: **12/31/04****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2003 report.			\$	<b>154,700</b> 1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	<b>170,430</b> 2
3. Under or (over) accrual (line 2 minus line 1).			\$	<b>15,730</b> 3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<b>168,800</b> 4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	<b>138</b> 5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<b>184,668</b> 7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1999	<b>153,298</b>	8	
	2000	<b>148,057</b>	9	
	2001	<b>149,243</b>	10	
	2002	<b>150,916</b>	11	
	2003	<b>163,886</b>	12	
<b>2004 Accrual = 2003 Tax \$163,886 x 1.03 = \$168,800 (rounded)</b>				
<b>Preferred Bookkeeping allocation \$2,274</b>				
<b>SIR Management allocation \$4,270</b>				

	<b>FOR OHF USE ONLY</b>		
13	FROM R. E. TAX STATEMENT FOR 2003	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2003 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME    Columbus Park Nrsng. Rehab Ctr.    COUNTY    Cook

FACILITY IDPH LICENSE NUMBER    0037960

CONTACT PERSON REGARDING THIS REPORT    Steve Lavenda

TELEPHONE    (847)236-1111    FAX #:    (847)236-1155

**A.    Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>16-17-401-005-0000</u>	<u>Long Term Care Property</u>	\$ <u>53,681.26</u>	\$ <u>53,681.26</u>
2. <u>16-17-401-006-0000</u>	<u>Long Term Care Property</u>	\$ <u>23,206.30</u>	\$ <u>23,286.30</u>
3. <u>16-17-401-026-0000</u>	<u>Long Term Care Property</u>	\$ <u>86,018.12</u>	\$ <u>86,918.13</u>
4. <u>See Attached</u>	<u>SIR Properties allocation</u>	\$ <u>79,702.01</u>	\$ <u>6,116.38</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>242,607.69</u></u>	\$ <u><u>170,002.07</u></u>

**B.    Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?      X   YES           NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C.    Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2003 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME    Columbus Park Nrsng. Rehab Ctr.    COUNTY    Cook

FACILITY IDPH LICENSE NUMBER    0037960

CONTACT PERSON REGARDING THIS REPORT    Steve Lavenda

TELEPHONE    (847)236-1111    FAX #:    (847)236-1155

**A.    Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A)	(B)	(C)	(D) <u>Tax</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u> <u>Nursing Home</u>
1.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
2.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
3.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
4.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
5.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
6.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
7.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
8.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
9.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
10.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
		<b>TOTALS</b>	\$ <u>                    </u>	\$ <u>                    </u>

**B.    Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?               YES               NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C.    Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A.
Square Feet:
29,685

B. General Construction Type:

Exterior
Brick

Frame

Number of Stories
6

C.
Does the Operating Entity?

☐ (a) Own the Facility
☒ (b) Rent from a Related Organization.
☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D.
Does the Operating Entity?

☒ (a) Own the Equipment
☒ (b) Rent equipment from a Related Organization.
☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E.
List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F.
Does this cost report reflect any organization or pre-operating costs which are being amortized?

☒ YES
☐ NO

If so, please complete the following:

1. Total Amount Incurred:
138,307

2. Number of Years Over Which it is Being Amortized:
30 yrs

3. Current Period Amortization:
4,610

4. Dates Incurred:
2003

Nature of Costs:
Hud Loan Fees

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		2002	\$ 300,000	1
2					2
3	TOTALS			\$ 300,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Various		1992		51,845		20	2,592	2,592	32,320	9
10	Various		1993		71,558		20	3,579	3,579	42,948	10
11	Various		1994		46,784		20	2,339	2,339	25,099	11
12	Various		1995		131,277		20	6,662	(6,662)	63,845	12
13	Various		1996		62,128		20	3,108	3,108	27,346	13
14	Various		1997		40,477		20	2,025	2,025	15,337	14
15	Various		1998		419,667		20	20,987	20,987	134,890	15
16	Various		1999		244,069		20	12,197	12,197	67,640	16
17	Various		2000		27,418		20	1,371	1,371	6,166	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		7,081,009	183,833		203,761	19,928	604,813	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		87,664	2,986		3,447	461	32,936	68
69	Financial Statement Depreciation			25,411			(25,411)		69
70	TOTAL (lines 4 thru 69)		\$ 8,263,896	\$ 212,230		\$ 262,068	\$ 36,514	\$ 1,053,340	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

## STATE OF ILLINOIS

Page 12B

Facility Name &amp; ID Number Columbus Park Nrsgr. Rehab Ctr.

# 0037960

Report Period Beginning:

01/01/04

Ending:

12/31/04

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 8,263,896	\$ 212,230		\$ 262,068	\$ 49,838	\$ 1,053,340	1
2	Boiler Work	2001	4,903		20	245	245	919	2
3	Water Tank	2001	2,375		20	119	119	435	3
4	Paving	2001	3,700		20	185	185	617	4
5	Roofing	2001	4,520		20	226	226	753	5
6	Linen/Storage	2001	61,335		20	3,067	3,067	9,456	6
7	Paint	2001	3,683		20	184	184	705	7
8	Window	2001	830		20	42	42	164	8
9	Sink	2001	866		20	43	43	169	9
10	Flooring	2001	1,093		20	55	55	210	10
11	Wallcover	2001	534		20	27	27	103	11
12	Door-Panic Device	2001	553		20	28	28	88	12
13	Hot Water Tank	2001	1,378		20	69	69	276	13
14	Hot Water Tank	2001	2,140		20	107	107	383	14
15	Hvac Work	2002	3,721		20	372	372	1,116	15
16	Hvac Work	2002	8,830		20	883	883	2,060	16
17	Freezer Door	2002	2,445		20	245	245	550	17
18	Dampers	2002	13,700		20	1,370	1,370	2,968	18
19	Refrigerator	2002	5,328		20	533	533	1,554	19
20	Painting	2002	1,821		20	182	182	516	20
21	Nurses Station Lights	2002	1,071		20	107	107	295	21
22	Water Heater	2002	2,108		20	176	176	395	22
23	Various Painting	2002	1,815		20	182	182	514	23
24	Window Screen	2003	782		20	78	78	130	24
25	Carpeting	2003	7,014		20	351	351	555	25
26	Hvac Work	2003	7,247		20	725	725	1,147	26
27	Water Heater	2003	4,840		20	242	242	464	27
28	Vent Covers	2003	6,700		20	335	335	503	28
29	Window Coverings	2003	9,429		20	471	471	707	29
30	Stairwell Alarm 1/2 Pd	2003	1,535		20	77	77	96	30
31	Compressor	2003	1,411		20	141	141	153	31
32	Fire Pump Work	2003	16,575		20	829	829	1,036	32
33	Smoke Detector	2003	3,225		20	161	161	175	33
34	TOTAL (lines 1 thru 33)		\$ 8,451,403	\$ 212,230		\$ 273,925	\$ 61,695	\$ 1,082,552	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

## STATE OF ILLINOIS

Page 12C

Facility Name &amp; ID Number Columbus Park Nrsgr. Rehab Ctr.

# 0037960

Report Period Beginning:

01/01/04

Ending:

12/31/04

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 8,451,403	\$ 212,230		\$ 273,925	\$ 61,695	\$ 1,082,552	1
2	Electrical Work	2003	11,026		20	551	551	597	2
3	Outside Lights	2003	1,060		20	53	53	57	3
4	Electrical Cable	2003	9,551		20	478	478	517	4
5	Water Pump	2003	2,305		20	115	115	125	5
6	Sprinkler System	2003	1,806		20	90	90	98	6
7	Middle Style Door	2003	1,453		20	73	73	145	7
8	Door Screens & Clips	2003	1,975		20	99	99	165	8
9	Block Heater With Hardware	2003	1,037		20	52	52	86	9
10	Replace Faucet	2003	1,175		20	59	59	78	10
11	Repair Elevator Doors	2003	1,010		20	51	51	97	11
12	Elevator Jack Packing	2003	2,184		20	109	109	155	12
13	Sprinkler System Repair	2003	2,355		20	118	118	147	13
14	Wallbase & Floor Tile	2003	986		20	53	53	53	14
15	Stairwell Alarm	2004	1,535		20	77	77	77	15
16	Hot Water Tank	2004	24,050		20	802	802	802	16
17	Electrical Work	2004	1,278		20	59	59	59	17
18	Hvac Work	2004	5,700		20	238	238	238	18
19	Boiler Tanks	2004	2,924		20	97	97	97	19
20	Elevator Work	2004	7,516		20	157	157	157	20
21	Telephone Work	2004	995		20	17	17	17	21
22	Nurse Call System	2004	4,274		20	71	71	71	22
23	Hvac Work	2004	2,946		20	37	37	37	23
24	Bathroom Work	2004	2,700		20	11	11	11	24
25	Hvac Work	2004	2,032		20	17	17	17	25
26	Hvac Work	2004	2,780		20	23	23	23	26
27	Elevator Work	2004	2,375		20	10	10	10	27
28	Blinds	2004	1,801		20	83	83	83	28
29	Door Repair	2004	895		20	37	37	37	29
30	Plumbing	2004	2,145		20	72	72	72	30
31	Miniblinds	2004	631		20	13	13	13	31
32	Water Heater Repair	2004	2,323		20	19	19	19	32
33	Water Heater Pump	2004	1,152		20	34	34	34	33
34	TOTAL (lines 1 thru 33)		\$ 8,559,379	\$ 212,230		\$ 277,700	\$ 65,470	\$ 1,086,746	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 8,559,379	\$ 212,230		\$ 277,700	\$ 65,470	\$ 1,086,746	1
2	A/C Repair	2004	1,041		20	22	22	22	2
3	A/C Repair	2004	1,370		20	34	34	34	3
4	Elevator Detector Edge	2004	1,490		20	56	56	56	4
5	Fire Alarm System	2004	2,129		20	71	71	71	5
6	Sprinkler System Repair	2004	1,103		20	5	5	5	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,566,511	\$ 212,230		\$ 277,888	\$ 65,658	\$ 1,086,934	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.



B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 8,566,511	\$ 212,230		\$ 277,888	\$ 65,658	\$ 1,086,934	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,566,511	\$ 212,230		\$ 277,888	\$ 65,658	\$ 1,086,934	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 8,566,511	\$ 212,230		\$ 277,888	\$ 65,658	\$ 1,086,934	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,566,511	\$ 212,230		\$ 277,888	\$ 65,658	\$ 1,086,934	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 8,566,511	\$ 212,230		\$ 277,888	\$ 65,658	\$ 1,086,934	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,566,511	\$ 212,230		\$ 277,888	\$ 65,658	\$ 1,086,934	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**	Year	Cost	Current Book	Life	Straight Line	Adjustments	Accumulated		
Constructed			Depreciation	in Years	Depreciation		Depreciation		
1	Totals from Page 12G, Carried Forward	\$ 8,566,511	\$ 212,230		\$ 277,888	\$ 65,658	\$ 1,086,934		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 8,566,511	\$ 212,230		\$ 277,888	\$ 65,658	\$ 1,086,934		34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 8,566,511	\$ 212,230		\$ 277,888	\$ 65,658	\$ 1,086,934	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,566,511	\$ 212,230		\$ 277,888	\$ 65,658	\$ 1,086,934	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1 Totals from Page 12I, Carried Forward		\$ 8,566,511	\$ 212,230		\$ 277,888	\$ 65,658	\$ 1,086,934		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34 TOTAL (lines 1 thru 33)		\$ 8,566,511	\$ 212,230		\$ 277,888	\$ 65,658	\$ 1,086,934		34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 8,566,511	\$ 212,230		\$ 277,888	\$ 65,658	\$ 1,086,934	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,566,511	\$ 212,230		\$ 277,888	\$ 65,658	\$ 1,086,934	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

## STATE OF ILLINOIS

Page 12-BLDG

Facility Name &amp; ID Number Columbus Park Nrsgr. Rehab Ctr.

# 0037960

Report Period Beginning:

01/01/04

Ending:

12/31/04

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	216	2002		\$ 7,013,521	\$ 182,896	35	\$ 200,386	\$ 17,490	\$ 601,158
5									
6									
7									
8									
Improvement Type**									
9	Elevator Work	2003		67,488	937	20	3,374	2,437	3,655
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.



XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 7,081,009	\$ 183,833		\$ 203,761	\$ 19,928	\$ 604,813	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

## STATE OF ILLINOIS

Page 12-REP

Facility Name &amp; ID Number Columbus Park Nrsg. Rehab Ctr.

# 0037960

Report Period Beginning:

01/01/04

Ending:

12/31/04

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	SIR Properties/SIR Management	1993		\$ 28,369	\$ 901	35	\$ 811	\$ (90)	\$ 9,321
5	SIR Properties/Preferred Bookkeeping	1993		15,109	480	35	432	(48)	4,964
6									
7									
8									
Improvement Type**									
9	Allocation - Preferred Bookkeeping	1997		18,869	422	20	943	521	7,367
10	Allocation - Preferred Bookkeeping	1999		150		20	7	7	41
11	Allocation - Preferred Bookkeeping	2000		946		20	47	47	209
12									
13	Allocation - SIR Management	1993		12,184	339	20	604	265	7,249
14	Allocation - SIR Management	1994		38		20	2	2	38
15	Allocation - SIR Management	1995		278		20	14	14	131
16	Allocation - SIR Management	1999		1,324		20	66	66	345
17	Allocation - SIR Management	2000		799		20	40	40	187
18									
19	Allocation - SIR Properties - SIR Management	1993		460	2	20	23	21	265
20	Allocation - SIR Properties - SIR Management	1994		270	7	20	14	7	142
21	Allocation - SIR Properties - SIR Management	1997		107	11	20	5	(6)	45
22	Allocation - SIR Properties - SIR Management	1998		1,718	172	20	86	(86)	558
23	Allocation - SIR Properties - SIR Management	1999		3,595	359	20	180	(179)	989
24	Allocation - SIR Properties - SIR Management	2002		112		20	6	6	14
25									
26	Allocation - SIR Properties - Preferred Bookkeeping	1993		245	1	20	12	11	141
27	Allocation - SIR Properties - Preferred Bookkeeping	1994		144	4	20	7	3	75
28	Allocation - SIR Properties - Preferred Bookkeeping	1997		57	6	20	3	(3)	24
29	Allocation - SIR Properties - Preferred Bookkeeping	1998		915	91	20	46	(45)	297
30	Allocation - SIR Properties - Preferred Bookkeeping	1999		1,915	191	20	96	(95)	526
31	Allocation - SIR Properties - Preferred Bookkeeping	2002		60		20	3	3	8
32									
33									
34									
35									
36									

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 87,664	\$ 2,986		\$ 3,447	\$ 461	\$ 32,936	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,642,547	\$ 296,196	\$ 25,567	\$ (270,629)	10	\$ 232,943	71
72	Current Year Purchases	18,823	15,340	1,117	(14,223)	10	1,117	72
73	Fully Depreciated Assets	64,748				10	64,748	73
74								74
75	TOTALS	\$ 1,726,118	\$ 311,536	\$ 26,684	\$ (284,852)		\$ 298,808	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 10,592,630	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 523,766	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 304,572	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (219,194)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,385,742	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

\*\*

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease                     .

9. Option to Buy: ☐ YES ☐ NO Terms:                                     \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 5,471

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Van	\$ 553.85	\$ 6,646	17
18	Allocation Preferred Bookkeeping			1,744	18
19	Allocation SIR Management			1,536	19
20					20
21	TOTAL		\$ 553.85	\$ 9,926	21

10. Effective dates of current rental agreement:

Beginning                     

Ending                     

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.                      /2005 \$                     

13.                      /2006 \$                     

14.                      /2007 \$                     

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b>  <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  COMMUNITY COLLEGE <input type="checkbox"/>  HOURS PER AIDE _____	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility		2	3	4
		Drop-outs	Completed	Contract	Total	
1	Community College Tuition	\$	\$	\$	\$	
2	Books and Supplies					
3	Classroom Wages (a)					
4	Clinical Wages (b)					
5	In-House Trainer Wages (c)					
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS	\$	\$	\$	\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$				

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.  
 SEE ACCOUNTANTS' COMPILATION REPORT

**XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 96,910	\$		\$ 96,910	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			36,195			36,195	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			104,891			104,891	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				52,500		52,500	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39 - 03				957	16,948		17,905	12
13	Other (specify): See Supplemental					123	50,064		50,187	13
14	TOTAL			\$		\$ 239,076	\$ 119,512		\$ 358,588	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 19,532	\$ 24,383	1
2	Cash-Patient Deposits	47,036	47,036	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,627,657	1,627,657	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	25,187	25,187	6
7	Other Prepaid Expenses	1,638	48,978	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <a href="#">See Attached Schedule</a>		298,163	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,721,050	\$ 2,071,404	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		300,000	13
14	Buildings, at Historical Cost		7,081,009	14
15	Leasehold Improvements, at Historical Cost	963,291	963,291	15
16	Equipment, at Historical Cost	629,126	1,955,605	16
17	Accumulated Depreciation (book methods)	(697,132)	(2,124,405)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <a href="#">See Attached Schedule</a>		132,160	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 895,285	\$ 8,307,660	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 2,616,335	\$ 10,379,064	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 230,187	\$ 230,187	26
27	Officer's Accounts Payable	17,690	17,690	27
28	Accounts Payable-Patient Deposits	50,940	50,940	28
29	Short-Term Notes Payable	1,280,000	1,280,000	29
30	Accrued Salaries Payable	144,514	144,514	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,066	15,066	31
32	Accrued Real Estate Taxes(Sch.IX-B)		168,800	32
33	Accrued Interest Payable	1,607	54,257	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	15,600	15,600	35
	<b>Other Current Liabilities(specify):</b>			
36	<a href="#">See Attached Schedule</a>	(1,119)	(1,119)	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,754,485	\$ 1,975,935	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,142,912	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<a href="#">See Attached Schedule</a>			43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$ 11,142,912	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,754,485	\$ 13,118,847	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 861,850	\$ (2,739,783)	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 2,616,335	\$ 10,379,064	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)



**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$ 932,869</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$ 932,869</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(18,019)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(53,000)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ (71,019)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 861,850</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 19

Facility Name &amp; ID Number Columbus Park Nrsg. Rehab Ctr.

# 0037960

Report Period Beginning: 01/01/04

Ending: 12/31/04

**VII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1			
	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 7,175,878	1
2	Discounts and Allowances for all Levels	(47,483)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,128,395	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	677,860	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 677,860	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	45,665	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,541	19
20	Radiology and X-Ray	4,070	20
21	Other Medical Services	55,028	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 109,304	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	1	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See Supplemental Schedule	10,217	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 10,217	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,925,777	30

2			
	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,394,753	31
32	Health Care	2,999,417	32
33	General Administration	1,864,742	33
	<b>B. Capital Expense</b>		
34	Ownership	1,207,712	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	358,588	35
36	Provider Participation Fee	118,584	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,943,796	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(18,019)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (18,019)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? cash basis If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Columbus Park Nrsg. Rehab Ctr.# 0037960Report Period Beginning: 01/01/04Ending: 12/31/04

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,972	2,051	\$ 73,326	\$ 35.75	1
2	Assistant Director of Nursing	1,935	2,050	54,391	26.53	2
3	Registered Nurses	9,309	9,807	233,976	23.86	3
4	Licensed Practical Nurses	31,345	33,739	690,751	20.47	4
5	Nurse Aides & Orderlies	100,592	107,072	950,723	8.88	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,816	12,568	111,183	8.85	8
9	Activity Director	2,002	2,091	26,123	12.49	9
10	Activity Assistants	10,625	11,140	79,633	7.15	10
11	Social Service Workers	7,982	8,585	99,829	11.63	11
12	Dietician					12
13	Food Service Supervisor	1,853	2,091	35,622	17.04	13
14	Head Cook	5,240	6,071	59,844	9.86	14
15	Cook Helpers/Assistants	17,532	18,982	151,800	8.00	15
16	Dishwashers					16
17	Maintenance Workers	3,662	3,968	40,645	10.24	17
18	Housekeepers	21,748	22,922	172,064	7.51	18
19	Laundry	10,713	11,407	89,667	7.86	19
20	Administrator	1,986	2,091	83,938	40.14	20
21	Assistant Administrator	1,733	1,986	36,245	18.25	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,966	8,801	98,682	11.21	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,545	4,987	105,023	21.06	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	254,556	272,409	\$ 3,193,465 *	\$ 11.72	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	monthly	\$ 13,800	01-03	35
36	Medical Director	monthly	7,200	09-03	36
37	Medical Records Consultant	monthly	4,128	10-03	37
38	Nurse Consultant	monthly	42,768	10-03	38
39	Pharmacist Consultant	monthly	3,759	10-03	39
40	Physical Therapy Consultant	174	9,899	10a-03	40
41	Occupational Therapy Consultant	162	9,220	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	70	4,004	10a-03	43
44	Activity Consultant	78	3,720	11-03	44
45	Social Service Consultant	40	2,105	12-03	45
46	Other(specify)				46
47	<u>Specialized Services Consultant</u>	monthly	6,324	12-03	47
48	<u>Director of Food Services</u>	monthly	22,032	01-03	48
49	TOTAL (lines 35 - 48)	524	\$ 128,959		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	266	\$ 10,407	10-03	50
51	Licensed Practical Nurses	8,857	330,652	10-03	51
52	Nurse Aides	146	2,085	10-03	52
53	TOTAL (lines 50 - 52)	9,269	\$ 343,144		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Columbus Park Nrsg. Rehab Ctr.

# 0037960

Report Period Beginning: 01/01/04

Ending: 12/31/04

## XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount		Description	Amount
Lee Martin	Administrator	0	\$ 83,938	Workers' Compensation Insurance	\$ 48,882		IDPH License Fee	\$ 18,353
Lisa Jackson	Asst. Admin.	0	36,245	Unemployment Compensation Insurance	59,864		Advertising: Employee Recruitment	18,353
				FICA Taxes	240,510		Health Care Worker Background Check	
				Employee Health Insurance	147,920		(Indicate # of checks performed <u>139</u> )	976
				Employee Meals	28,987		Advertising & Promotion	1,866
				Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscription	7,089
				Chicago Head Tax	7,620		Licenses & Permits	4,442
				401K Matching	2,785		Yellow Page Advertising	7,439
				Other Employee Benefits	4,765		Allocation Preferred Bookkeeping	212
							See Supplemental Schedule	219
							Less: Public Relations Expense ( )	
							Non-allowable advertising	(1,866)
							Yellow page advertising	(7,439)
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 120,183					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
					\$ 541,333			\$ 31,291
Description			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
SIR Management - Fees			\$ 4,320	Description	Line #	Amount	Description	Amount
Director of Administrative Services - SIR Management			27,216				Out-of-State Travel	\$
Ancillary Administrative Charges - SIR Mgmt			48,600					
See Supplemental Schedule			468,495				In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 548,631					
(Attach a copy of any management service agreement)								
C. Professional Services							Seminar Expense	2,425
Vendor/Payee	Type		Amount				Allocation Preferred Bookkeeping	169
Frost, Ruttenberg & Rothblatt	Accounting		\$ 14,575				Allocation SIR Management	323
Preferred Bookkeeping	Accounting		27,300				Entertainment Expense ( )	
Preferred Bookkeeping	Bookkeeping		77,760				(agree to Sch. V, line 24, col. 8)	
Preferred Bookkeeping	Computer Support		5,184					
SIR Management	Dir of Regulatory Services		17,496					
Personnel Planners	Unemployment Consultant		2,344					
LTC Solutions	Computer Services		1,320					
ICS Solutions	Computer Services		224					
Stuart Sikes	Legal (adjusted page 5)		96					
Scott Forrest Stern & Assoc.	Legal (adjusted page 5)		427					
Michael Best & Freidrich	Legal (adjusted page 5)		3,240					
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$		
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 149,966					

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbus Park Nrsg. Rehab Ctr.

STATE OF ILLINOIS

# 0037960

Report Period Beginning:

01/01/04

Ending:

Page 23

12/31/04

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Illinois Council on Long Term Care \$9,880
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 20,415 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 118,584  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 28,987 Has any meal income been offset against related costs? No Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? None  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.